MEDI-CAL REDETERMINATION
FORMER SSI/SSP RECIPIENT
ADULT/CHILD—NO LONGER DISABLED

1. Name First Middle Last

2. Home address Street City ZIP code

Mailing address (If different)

Telephone number
( )

COUNTY USE ONLY

State number

3. List all persons regularly living in your household (include persons absent due to hospitalization or solely because of school).

Name	Social Security Number	Sex M/F	Birthdate Month/Day/Year	Relationship To You
Self				
a.				
b.				
c.				
d.				
e.				

If not enough room, list additional members of your household on page 4.

❒ Potential Sneede

Medical Support ❒ Yes ❒ No

❒ CA 2.1

COMPLETE THE FOLLOWING INFORMATION FOR YOURSELF, YOUR SPOUSE, IF HE/SHE IS LIVING WITH YOU, AND YOUR CHILD(REN) YOU LISTED IN 3 WHO ARE UNDER 21 AND HAVE NEVER BEEN MARRIED.

4. Is anyone currently receiving a cash grant or Medi-Cal? ❒ Yes ❒ No
If yes,

Name(s)	CASH GRANT		MEDI-CAL ONLY	
	Yes	No	Yes	No

5. Complete the following about your living arrangements:

- ❒ Rent a room, apartment, house, or trailer.
- ❒ Pay for room and board.
- ❒ Receive free room.
- ❒ Receive free room and board.
- ❒ Live in a board and care facility.
- ❒ Living in a nursing home or hospital.
- ❒ Living in a home, trailer, mobile home, boat, or motor vehicle you own or are buying.

6. Do you and/or your spouse and/or child(ren) own any real property (land, buildings) which you do not now live in? ❒ Yes ❒ No

If yes: Full value (from tax statement) $ _____
Amount owed $ _____
Yearly income from property $ _____
List yearly expenses on property (including interest payments, taxes, assessments, utilities, insurance, and upkeep and repairs) on page 4.

7. Do you and/or your spouse and /or child(ren) have any of the following property?

Item	Yes	No	Person Who Owns Property	Amount (or Market Value)	Amount Owed
a. Cash, uncashed checks, or money in the house or anywhere else?					
b. Savings and/or checking account(s)? Where:_____ Account number _____ Where:_____ Account number _____					
c. IRA, KEOGH, deferred compensation, retirement account, or annuity? Enter which type(s) _____ _____ _____					
d. Stocks, bonds, certificate of deposit, money market or mutual funds? Enter which type(s) _____ _____					
e. Notes, mortgages, trust deeds, sales contracts?					
Class (from registration)					
f. Motor vehicle?					
g. Motor vehicle?					
h. Boat, camper, trailer?					
i. Burial reserve(s)/trust(s)?					
j. Burial plot(s) for other than family members?					
k. Business equipment, tools, inventory (list on page 4)?					
l. Jewelry over $100, mineral rights, mining claim, other asset/resource?					

8. Do you and/or your spouse and /or child(ren) have life insurance? ❒ Yes ❒ No
If yes, complete for each policy:

Person Insured	Owner of Policy	Face Value	Current Cash Value

9. Have you and/or your spouse and/or child(ren) transferred, sold, or given away any real or personal property (including money) during the past 30 months? ❒ Yes ❒ No
If yes, list:

Description of Item	Date of Transfer, Sale, or Gift	Value	Amount Received
		$	$
		$	$

10. Do you and/or your spouse and /or child(ren) have Medicare coverage? ❒ Yes ❒ No
If yes,

Person Covered	Medicare Number	Premium Deducted From Check
		❒ Yes ❒ No
		❒ Yes ❒ No

COUNTY USE ONLY

❒ Potential Sneede

Disposition of proceeds:

Note: Refer to transfer of property regs. in Title 22

11. Do you and/or your spouse and /or child(ren) have health or hospitalization insurance? ❒ Yes ❒ No
If yes,

Person(s) Insured	Type of Insurance	Monthly Premium Paid
		$
		$

12. Do you and/or your spouse and /or child(ren) receive any of the following types of income?

Type	Yes	No	Person Receiving Income	Monthly Amount
a. Cash grant				$
b. Social Security				$
c. Pension or retirement				$
d. Unemployment				$
e. Disability insurance				$
f. V.A. benefits				$
g. Child support or alimony				$
h. Interest income or dividends				$
i. Other unearned income (include gambling/lottery/bingo winnings, lump sum payments, inheritance)				$

13. Do you and/or your spouse and /or child(ren) have earned income? ❒ Yes ❒ No
If yes,

Person Employed	How Often Paid	Days Per Week Worked	Gross Income Per Pay Period	Expenses (list on page 4) (Include Taxes, Child Care, And Other Deductions From Check)	Total Miles To/From Work
			$	$	
			$	$	
			$	$	

14. Are you and/or your spouse and /or child(ren) self-employed? ❒ Yes ❒ No

If yes, will income this year be the same as last year? ❒ Yes ❒ No

If yes, attach copy of last year's tax statement.

If no, attach copy of business records showing current income, expenses, etc.

15. Do you and/or your spouse pay child support or alimony under a court order or based on an agreement with the District Attorney? ❒ Yes ❒ No
If yes,

Amount paid $ _____ To whom _____

COUNTY USE ONLY

❒ Potential Sneede

16. Are you and/or your spouse and/or child(ren) a student? ❒ Yes ❒ No

If yes,

Student	School	Income Received For School (Loans, Scholarships, Work Study Grants, etc.)	Expenses (Tuition, Books, Mileage, Child Care, etc.) (List on Page 4)

17. Information about a Social Security Administration (SSA) appeal for you, your spouse, or your child(ren):

a. Do you currently have a pending appeal on your SSI case with the SSA because you do not agree with SSA's decision that you are ***"no longer disabled?"*** ❒ Yes ❒ No

If "yes," write the name(s) of person(s) who has the pending SSA appeal:

_____

When was/were the appeal(s) filed with SSA? _____ Month/Year

b. Have you reapplied for SSI benefits because of a physical and/or emotional problem(s) that is either ***new*** or that you did not tell SSA about before? ❒ Yes ❒ No

18. Information about a ***new*** physical and/or emotional problem(s):

a. Do you have a physical and/or emotional problem(s) that you did not tell SSA about before SSA made the decision that you are no longer disabled? ❒ Yes ❒ No

b. Is this physical and/or emotional problem(s) expected to last at least a year? ❒ Yes ❒ No

c. Please explain this physical and/or emotional problem(s): _____

_____

19. Additional information (identify additional information for other pages by question number)

_____

_____

_____

_____

20. The following questions do not affect your eligibility for Medi-Cal:

a. Are you interested in medical or dental services for any family member under age 21 through the Child Health Disability Prevention Program (CHDP)? ❒ Yes ❒ No

b. If any family member has given birth within the last three months or is breastfeeding a child(ren), she may be eligible for the Special Supplemental Food Program for Women, Infants, and Children (WIC). Do you want information about WIC? ❒ Yes ❒ No

- **I declare under penalty of perjury that the answers I have given are true and correct to the best of my knowledge.**
- **I agree to tell the county welfare department within 10 days if there are any changes in my (or the person's on whose behalf I am acting) income, property, expenses, or in the persons in the household or of any change of address.**
- **I understand that I may be asked to prove my statements and that my eligibility may be subject to quality control review.**
- **I understand that the county is required by law to keep any information I provide confidential.**
- **I understand that if I am dissatisfied with actions taken by the county welfare department, I have the right to a state hearing.**

I realize that if I deliberately make false statements or withhold information, I (or the person on whose behalf I am acting) may lose Medi-Cal eligibility and/or I may be prosecuted for fraud.

Signature of Applicant

Signature of Person Acting for Applicant | Relationship

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❒ Proof of SSI appeal, if not apparent on MEDS

❒ DED packet on new or not previously considered condition

❒ CHDP brochure given

_____ Date

❒ CHDP referral

❒ WIC referral date for pregnancy, breastfeeding, postpartum, or parent/guardian of child under age 5

_____ Date

E.W.

Date